VA/DoD Joint Executive Council
Strategic Plan
Fiscal Years 2008-2010

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Department of Veterans Affairs and Department of Defense Joint Strategic Plan for Fiscal Years 2008 - 2010

Mission

To improve the quality, efficiency, and effectiveness of the delivery of benefits and services to veterans, servicemembers, military retirees, and their families through an enhanced Department of Veterans Affairs (VA) and Department of Defense (DoD) partnership.

Vision Statement

A world-class partnership that delivers seamless, cost-effective, quality services to beneficiaries and value to our nation.

Guiding Principles

- **Collaboration** – to achieve shared goals through mutual support of both our common and unique mission requirements.
- **Stewardship** – to provide the best value for our beneficiaries and the taxpayer.
- **Leadership** – to establish clear policies and guidelines for VA/DoD partnership, promote active decision-making, and ensure accountability for results.

Strategic Goals

Goal 1 – Leadership, Commitment, and Accountability
Promote accountability, commitment, performance measurement, and enhanced internal and external communication through a joint leadership framework.

Goal 2 – High Quality Health Care
Improve the access, quality, effectiveness, and efficiency of health care for beneficiaries through collaborative activities.

Goal 3 – Seamless Coordination of Benefits
Improve the understanding of, and access to, services and benefits that uniformed servicemembers and veterans are eligible for through each stage of their life, with a special focus on ensuring a smooth transition from active duty to veteran status.

Goal 4 – Integrated Information Sharing
Ensure that appropriate beneficiary and medical data is visible, accessible, and understandable through secure and interoperable information management systems.

Goal 5 – Efficiency of Operations
Improve management of capital assets, procurement, logistics, financial transactions, and human resources.

Goal 6 – Joint Medical Contingency/Readiness Capabilities
Ensure the active participation of both agencies in Federal and local incident and consequence response through joint contingency planning, training, and conduct of related exercises.

GOAL 1 – Leadership, Commitment, and Accountability

Promote accountability, commitment, performance measurement and enhanced internal and external communication through a joint leadership framework.

VA and DoD will maintain a leadership framework to promote successful partnerships, institutionalize change, and sustain momentum and collaboration into the future. This framework will consist of the Joint Executive Council (JEC), the Health Executive Council (HEC), the Benefits Executive Council (BEC), and other necessary sub-councils or Working Groups. The JEC will be responsible for developing a plan to increase the exchange of knowledge and information between the Departments, as well as with external stakeholders. In addition, after several health care and transition issues came to light at the Walter Reed Army Medical Center in February 2007, VA and DoD established the Senior Oversight Committee (SOC), co-chaired by the Deputy Secretary of each Department to address high-priority issues. The following Lines of Action (LOAs) were created to address these issues.

- Disability Evaluation System
- Traumatic Brain Injury/Post Traumatic Stress Disorder
- Case Management
- VA/DoD Data Sharing
- Facilities
- Clean Sheet Analysis
- Legislation – Public Affairs
- Personnel – Pay Issues

The SOC is scheduled to finish its work in May 2008, and any remaining responsibilities will be shifted to the JEC at that time. The recommendations of commissions, task forces, advisory committees, and review groups have also been reviewed and where relevant, incorporated into this Joint Strategic Plan (JSP).

OBJECTIVE 1.1

Improve the access, quality, cost effectiveness, and efficiency with which benefits and services are provided to beneficiaries of VA and DoD through increased resource sharing and organizational collaboration.

STRATEGIES AND PERFORMANCE MEASURES (PM)

STRATEGY 1.1

The JEC will provide strategic direction for VA/DoD collaboration with the development and publication of a JSP.

(a) The JEC will monitor JSP progress at quarterly meetings.

(b) The JEC quarterly meetings will provide a forum for issue resolution between the Departments.

(c) The JEC will develop appropriate plans to overcome impediments to meeting stated goals and objectives when specific JSP strategies and initiatives are not met.

PM 1.1
Update and complete coordination of VA/DoD JSP for fiscal years 2009 – 2011 by September 30, 2008. VA and DoD will seek JEC co-chair approval by October 31, 2008.

OBJECTIVE 1.2

Improve stakeholder awareness of sharing and collaboration initiatives, and communicate and promote results and best practices throughout the two Departments and to external stakeholders.

The communications efforts in support of the Joint Strategic Plan also reflect the values, mission, and goals of both the Military Health System (MHS) Strategic Plan and the VA Strategic Plan.

STRATEGIES AND PERFORMANCE MEASURES (PM)

STRATEGY 1.2
The VA/DoD JEC will foster and support clear communications by widely reporting collaborative activities and results each year to members of Congress, the Departmental Secretaries, and internal/external stakeholders.

(a) The JEC will foster and support communication of the ongoing collaboration and resulting best practices by using websites and detailing VA/DoD resource sharing initiatives and accomplishments. The websites will be updated regularly.

(b) All communications efforts will reflect the JEC's priorities. The key messages will be a proactive way to share the goals, accomplishments, and best practices of the JEC, HEC, and BEC. Tailored communications plans will be developed around each of the key messages which correspond with the SOC's lines of action.

For fiscal year 2008, the key messages will incorporate the many different task force recommendations and commissions and highlight the areas of most importance to both Departments.

(1) DoD and VA are committed to continued emphasis on the sharing of DoD and VA electronic medical records. The goal is to enable the Departments to

better share the vast array of beneficiary data, medical records, and other health care information through secure and interoperable information systems, which will allow for a seamless continuum of care.

(2) There is a new focus on the collaboration in the provision of specialized care to servicemembers and veterans. This includes mental health services and care of the severely wounded, particularly those with traumatic brain injury and post traumatic stress disorder.

(3) Both Departments have demonstrated that joint operations and resource sharing improve the effectiveness and efficiency of health care services and benefits to veterans, servicemembers, military retirees, and eligible dependents.

(4) Both the DoD and the VA are working to improve case management and standardize the delivery of care across the continuum; from illness or injury to recovery and beyond.

(5) DoD and VA are working closely to provide a seamless and transparent disability process, one that is jointly administered by both organizations.

(6) It is important to ensure the compassionate, timely, accurate and standardized personnel pay and financial support is available for wounded, ill and injured servicemembers.

(7) DoD and VA recognize that legislation may be necessary to implement the recommendations of the President's Commission on Care for America's Returning Wounded Warriors, and other task force and commission recommendations.

(8) Assessments of all medical hold and holdover facilities will be conducted to identify areas in need of improvement as well as the associated funding. This includes the accelerated transition of Walter Reed Army Medical Center services to Bethesda and Fort Belvoir.

PM 1.2
An update on the joint communications efforts will be reported to the JEC quarterly.

PM 1.2
The execution of the tactics outlined within the individual communications plans, which are developed by the SOC LOAs and the Communications Working Group, will be monitored and reported to the JEC as they are implemented.

PM 1.2
Content analysis of news articles will be conducted to identify any changing attitudes reflected over time.

GOAL 2 – High Quality Health Care

Improve the access, quality, effectiveness, and efficiency of health care for beneficiaries through collaborative activities.

VA and DoD will expand the use of partnering and sharing arrangements to improve services for all beneficiaries. Collaboration will continue on developing joint guidelines and policies for the delivery of high-quality care and the assurance of patient safety. VA and DoD will engage in joint training in multiple disciplines, including ancillary services, and explore opportunities to enhance collaborative activities in Graduate Medical Education (GME). Sharing in deployment-related health care information, research and development, and care coordination will be aggressively supported and encouraged. For dual beneficiaries, VA and DoD will ensure that the two systems are mutually supportive.

OBJECTIVE 2.1

Be leaders in developing and delivering innovative clinical processes and programs that enhance the quality of health care.

STRATEGIES AND PERFORMANCE MEASURES (PM)

STRATEGY 2.1 (a)
The HEC Patient Safety Working Group will oversee the design, development, and distribution of joint patient safety initiatives, consistent with legal requirements on uses of quality assurance information.

(1) The VA National Center for Patient Safety (NCPS) and the DoD Patient Safety Center (PSC) will continue to share information on patient safety alerts and advisories potentially relevant to both health care systems. Examples of each shared alert or advisory will be reported in the respective HEC monthly progress report during the month the alert or advisory occurs. By June 30, 2008 each agency will provide evidence of the final, approved policy or handbook, containing the language related to sharing of alerts and advisories.

(2) Obtain signed DoD/VA Data Use Agreement (DUA) regarding sharing data, information, and analyses on patient safety event categories is required before data sharing may begin. Obtain agreement by both Departments by December 31, 2007. The Patient Safety WG will assist in coordination, however these actions are outside the authority of their WG.

(3) VA NCPS and the DoD PSC will share data, information, and analyses on the patient safety event category of unintentionally retained surgical items (also

referred to as “foreign bodies left in after a surgery or procedure”) by January 31, 2008.

(4) VA NCPS and the DoD PSC will share data, information, and analyses on the patient safety event category of incorrect surgery or invasive procedures (wrong site, wrong side, wrong patient, etc.) by January 31, 2008.

(5) VA NCPS and the DoD PSC will share data, information, and analyses on the patient safety event category of patient falls that cause serious injury, i.e. resulted in fractures, head injuries, etc., by January 31, 2008.

(6) VA NCPS and the DoD PSC will share data, information, and analyses on the patient safety event category of inpatient suicides by May 31, 2008.

(7) VA NCPS will share information on the patient safety event category of pressure ulcers with the DoD PSC by July 31, 2008.

(8) The DoD PSC will request a DoD Scientific Advisory Panel (SAP) Special Study on the topic of pressure ulcers in DoD facilities by November 2007 with study completion, if accepted, by October 31, 2008. DoD will share the information from approved study with VA by November 30, 2008.

(9) The DoD PSC and VA NCPS will explore the feasibility of establishing a joint Working Group to share information on usability and other patient safety topics relevant to VA and DoD purchasing and procurement of medical devices.

PM 2.1 (a) (2) & (3)
The Patient Safety Working Group monthly progress report for November 2007 will include summary reports related to unintentionally retained surgical items, incorrect surgery, invasive procedure, and falls. The summary reports will show analyses of selected subtypes of events, and information on root causes and contributing factors that lead to these types of adverse events in health care systems, as well as examples of interventions implemented in both systems by November 30, 2007.

PM 2.1 (a) (5)
The Patient Safety Working Group monthly progress report for August 2008 will include a summary report related to inpatient suicides. The summary report will show analyses of selected subtypes of events, and information on root causes and contributing factors that lead to these types of adverse events in health care systems, as well as examples of interventions implemented in both systems by August 31, 2008.

PM 2.1 (a) (8)
The DoD PSC and VA NCPS will prepare a report on the feasibility of establishing a joint Working Group to share information on usability and other patient safety topics relevant to VA and DoD purchasing and procurement medical devices that takes into account current capabilities and processes in both Departments by December 31, 2007.

STRATEGY 2.1 (b)
The HEC Evidence Based Practice Working Group will use clinically diverse and collaborative groups to develop, update, adapt, adopt and/or revise four evidence-based clinical practice guidelines (EBCPGs) annually.

(1) For each EBCPG, include recommendations for at least one performance measure that is based on a Level I or Level II-1 evidence. (e.g. Level I includes at least one properly conducted randomized controlled trial and Level II-1 is a well-designed controlled trial without randomization.)

(2) For each EBCPG, develop provider education tools no later than twelve months after the EBCPG is issued.

(3) The Evidence Based Practice Working Group will formally introduce via podium presentations, abstracts, or exhibits, two EBCPGs at professional conferences, within six months of their completion date.

(4) The Evidence Based Practice Working Group will collaborate with national professional health organizations when judged to be beneficial to VA and DoD to develop individual clinical practice guidelines.

PM 2.1 (b)
Achieve National Guidelines Clearinghouse (NGC) approval and recognition on all issued EBCPGs within one year after submission.

PM 2.1 (b) (2)
One hundred percent (100%) of EBCPGs will have implementation tools developed within 12 months of issue.

PM 2.1 (b) (4)
The four approved EBCPG for each fiscal year will be introduced on the website within six months of their completion date.

STRATEGY 2.1 (c)
By December 31, 2008 the HEC Mental Health Working Group will work together to explore mechanisms to identify individuals with serious mental health issues or who are at risk for suicide in order to insure appropriate assessment and indicated treatment are offered.

(1) The HEC Mental Health Working Group will develop processes by December 31, 2008 to assess the extent to which referrals made to Veterans Health Affairs (VHA) resources for mental health evaluation and care at Post Deployment

Health Re-Assessments (PDHRA) result in follow-up VHA evaluations and ongoing mental health care.

(2) The HEC Mental Health Working Group will explore methods for assessing VA and DoD mental health data to determine whether Post Deployment Health Assessment (PDHA) and/or PDHRA responses are predictive of which returning servicemembers come to VHA for evaluation and care.

PM 2.1 (c) (2)
The rate of follow-up for referral 1) evaluation and 2) mental health care will be determined by September 30, 2009.

STRATEGY 2.1 (d)
The HEC Mental Health Working Group will coordinate to plan and implement shared training programs to increase the use of evidence-based psychotherapy and pharmacotherapy approaches in both Departments.

(1) VA and DoD will continue to offer joint Cognitive Processing Therapy (CPT) training, a combination of prolonged exposure and cognitive behavioral therapy for Post Traumatic Stress Disorder (PTSD), so that a consistent approach to this therapy is utilized by providers in both Departments.

(2) Training in Prolonged Exposure Therapy for PTSD in both VA and DoD will be developed and fully planned for implementation by June 30, 2008.

(3) Training for primary care providers in both VA and DoD on appropriate pharmacotherapy for PTSD will be developed and fully planned for implementation by June 30, 2008.

PM 2.1 (d)
VA and DoD will report to the HEC on the annual number of trainees for each training program at the end of each fiscal year.

STRATEGY 2.1 (e)
The HEC Mental Health Working Group will coordinate or standardize measures and definitions of suicide nomenclature between VA and DoD.

PM 2.1 (e)
Both Departments will publish policy memoranda which establish common nomenclature and data or crosswalks between alternative systems for metrics regarding suicide by September 30, 2008.

OBJECTIVE 2.2

Actively engage in collaborative GME, joint in-service training, and continuing education activities, which will enhance quality, effectiveness and efficiency of health care.

STRATEGIES AND PERFORMANCE MEASURES (PM)

STRATEGY 2.2 (a)
The HEC Graduate Medical Education Working Group will examine opportunities for greater VA/DoD GME collaboration and present findings and recommendations to the HEC.

(1) The Graduate Medical Education Working Group will address key issues of the impact analysis and lessons-learned study of the pilot project (placement of military residents into VA affiliated residency programs) in order to try to expand current participation.

PM 2.2 (a) (1) (a)
DoD: Fifty percent (50%) increase in the number of military obligated trainees applying for positions outside the National Resident Matching Program ("the match") in VA-affiliated university-sponsored residency programs within two academic years (2008 – 2010).

PM 2.2 (a) (1) (b)
VA: Annual percentage of DoD applicants placed into VA-affiliated, university-sponsored residency programs will be 80% or greater (2008 – 2010) of positions offered.

STRATEGY 2.2 (b)
The HEC Graduate Medical Education Working Group will conduct a needs assessment of GME programs which may have been adversely impacted by the Base Realignment and Closure Commission (BRAC) and present a preliminary assessment with recommended VA/DoD actions.

(1) Complete a needs assessment of GME programs in the National Capital Area and San Antonio. Include list of residency programs in National Capital Area by specialty/sub-specialty area, accreditation sponsor, number of residents per program, potential redundancy or duplication in programs that overlap; rank programs that will likely be adversely impacted by BRAC and report preliminary findings to the HEC no earlier than September 30, 2008. Report semi-annually on progress in merging duplicate programs and in collaborations with VA.

STRATEGY 2.2 (c)
The HEC GME Working Group will pilot a Seamless Transition for Trainees Program at one site based on approval of the HEC.

(1) Obtain HEC approval (via Executive Decision Memorandum [EDM]) of site by December 31, 2007.

(2) Agree on implementation procedures at the pilot site by May 31, 2008.

(3) Begin the pilot by July 31, 2008.

(4) Evaluate the pilot and report results/recommendations to HEC by June 30, 2009.

STRATEGY 2.2 (d)
The HEC Continuing Education and Training WG will enhance the existing shared training partnership between VA and DoD to provide additional and improved shared training by optimizing the distributed learning architecture (see Footnote 1 for definition) which supports the sharing of continuing education and in-service training programs for health care professionals in VA and DoD. The Working Group will:

(1) Refine the written plan for aligning the distributed learning architectures within VA and DoD to support increased shared training between the departments utilizing distance learning modalities while minimizing the additional resources necessary to support shared training by October 31, 2007.

(2) Encourage the ongoing use of shared training strategies between VA and DoD and within the uniformed services, taking advantage of the VA and DoD distributed learning architectures and minimizing the resources necessary to share training.

(3) Formal DoD and VA approval for a committee to coordinate the identification, vetting and distribution of shared training within DoD and between VA and DoD by September 30, 2008.

(a) Establish a committee to conduct a demonstration of how to coordinate the identification, vetting and distribution of shared training within DoD and between VA and DoD by November 30, 2007.

(b) Seek formal approval of a committee to coordinate the identification, vetting and distribution of shared training within DoD and between VA and DoD by September 30, 2008.

(4) Develop and implement a strategy for utilizing the Learning Management Systems (LMSs) (see footnote 3) to assess the participation of VA and DoD personnel in shared training by September 30, 2010. (Note: achieving this objective is dependent upon the successful deployment of the LMS in VA and DoD.)

(a) Develop a strategy for utilizing the VA and DoD LMSs to quantify the participation of VA and DoD personnel in shared training by September 30, 2008.

(b) Pilot a strategy for utilizing the VA and DoD LMSs to assess the participation of VA and DoD personnel in shared training by September 30, 2009.

(c) Implement a fully operational system for utilizing VA and DoD LMSs to quantify the participation of VA and DoD personnel in shared training by September 30, 2010.

(5) Determine the feasibility of conducting selected impact evaluations to assess the return on investment (ROI) of shared training by June 30, 2008.

PM 2.2 (d)
In fiscal year 2008, maintain the fiscal year 2007 overall volume of shared training which represents a 150% increase over fiscal year 2005 and generate a cost avoidance of $7,000,000 while increasing the amount of shared web based training by 50% over fiscal year 2006. Introduce selected emerging technologies to enhance shared training (e.g. IP3 based training, streaming video to the desk top and cell phone delivery of training) by September 30, 2008.

PM 2.2 (d) (4)
Report to the HEC quarterly on the volume of shared training by individual participants by December 31, 2010.

STRATEGY 2.2 (e)
The HEC Continuing Education and Training Working Group will continue to facilitate the development and management of a VA/DoD Facility Based Educators community of practice (see footnote 2 for definition) to increase shared training initiatives between VA Health Care Facilities and DoD Military Treatment Facilities (MTFs).

(1) Establish a VA DoD Facility Based Educators Community of Practice by November 30, 2007.

(2) Provide a virtual forum (email group, virtual meeting room, and knowledge management site) for the members of the Facility Based Educators Community of Practice by January 31, 2008 to increase communications and the development of shared training between VA and DoD Health Care Facilities.

(a) Establish an email group as part of the virtual forum by November 30, 2007 to support the members of the Facility Based Educators Community of Practice.

(b) Establish a Knowledge Management site as part of the virtual forum by November 30, 2007 to support the members of the Facility Based Educators Community of Practice.

(c) Establish a virtual meeting room site as part of the virtual forum by January 31, 2008 to support the members of the Facility Based Educators Community of Practice.

(3) Identify local VA and DoD facility based educators and begin providing them with in-service training in the area of shared training by May 31, 2008 utilizing the virtual forum developed in Strategy 2.2 (e) (2).

(4) Launch special training initiatives for selected high priority clients (see footnote 4) which can benefit from shared training by September 30, 2008.

(a) Develop a strategy for providing shared training to high priority clients by November 30, 2007 utilizing the VA/DoD Federal Health Care Facility – North Chicago, joint venture site as the pilot.

(b) Complete a pilot of a strategy for providing shared training to high priority clients by March 31, 2008 utilizing the VA/DoD Federal Health Care Facility – North Chicago, joint venture site as the pilot.

(c) Begin providing all joint venture sites with shared training upon request based on the lessons learned at the VA/DoD Federal Health Care Facility – North Chicago, joint venture site by September 30, 2008.

(5) Develop and implement a strategy for the joint VA and DoD identification and/or development of training programs to meet the needs of high priority clients in VA and DoD by September 30, 2008.

(a) Develop a strategy for identifying and/or developing training programs for high priority clients by March 31, 2008 utilizing the VA/DoD Federal Health Care Facility – North Chicago, joint venture site leaders and managers as the target population for the pilot.

(b) Conduct a pilot joint program development exercise for high priority clients by March 31, 2008 utilizing the VA/DoD Federal Health Care Facility – North Chicago, joint venture site leaders and managers as the target population.

(c) Begin providing training to joint venture site leaders and managers by September 30, 2008 as requested based on the data gathered from the pilot at the VA/DoD Federal Health Care Facility – North Chicago, joint venture site.

(6) Develop enhanced methods and procedures utilizing LMSs for collecting shared training data at the local level in VA and DoD by September 30, 2010.

(a) Develop a strategy for utilizing LMSs to assess the participation of VA and DoD personnel in local shared training by September 30, 2008.

(b) Pilot a strategy for utilizing LMSs to assess the participation of VA and DoD personnel in local shared training by September 30, 2009.

(c) Implement a fully operational system for utilizing LMSs to assess the participation of VA and DoD personnel in local shared training by September 30, 2010.

PM 2.2 (e) (1)
Establish a VA/DoD community of practice which incorporates all of the members of existing facility based educator communities of practice in VA, DoD and the uniformed services by November 30, 2007.

PM 2.2 (e) (2)
Provide a virtual forum composed of an email group, virtual classroom and knowledge management site to the VA/DoD facility based educators' community of practice by January 31, 2008.

PM 2.2 (e) (3)
Commencement of an in-service training program in the area of shared training for local VA and DoD facility based educators by May 31, 2008.

PM 2.2 (e) (4)
Implementation of special training initiatives for selected high priority clients which can benefit from shared training by September 30, 2008.

PM 2.2 (e) (5)
Implementation of a fully operational system for utilizing LMSs to assess the participation of VA and DoD personnel in local shared training by September 30, 2011.

PM 2.2 (e) (6)
Development and implementation of a strategy for the joint identification and/or development of training programs to meet the needs of high priority clients in VA and DoD by September 30, 2008.

(*Footnote I: For the purpose of this report, Distributed Learning Architecture is defined as the hardware and software necessary to convey training between the partners; the operational methods and procedures to manage the shared training venture and to assure

the timely and effective sharing of training; and the commitment of leaders responsible for training in both agencies to the success of the venture.)

(*Footnote II: for the purpose of this report, community of practice will be defined as being composed of facility based educators in VHA and DoD possessing similar professional needs and interests who also share a common mission and who work in similar ways to accomplish that mission.)

(*Footnote III: LMS as used in this context is a web based training tracking system used to collect and report education and training data. Many Federal agencies including DoD, the uniformed services and VA are in various stages of implementing their respective LMSs. Due to variability of implementation and platforms, there are a number of technical requirements that will need to be met before the LMS systems can be used to generate reports on participation in shared training.)

(*Footnote IV: 'High priority client' as used in this context refers to learners designated by VHA or DoD leadership as having special training needs which are essential in meeting the VHA and or DoD health care mission.)

OBJECTIVE 2.3

The HEC Deployment Health Working Group shall identify and foster opportunities for sharing information and resources between VA and DoD in the areas of deployment health surveillance, assessment, follow-up care, health risk communication, and research and development.

STRATEGIES AND PERFORMANCE MEASURES (PM)

STRATEGY 2.3 (a)

The HEC Deployment Health Working Group will identify opportunities to share information between DoD and VA on health surveillance of military populations, including identification of cohorts with specific exposures or diseases.

(1) Annually review DoD's identification of cohorts who participated in the testing of chemical and biological warfare agents from 1942 to 1975, DoD's ongoing provision of data to VA, and VA's outreach efforts to these cohorts.

(2) Annually review DoD's identification of servicemembers who were injured in combat or non-combat incidents and who have embedded fragments, DoD's provision of data to VA on these individuals, and VA's medical follow-up activities.

(3) Annually review DoD and VA efforts related to traumatic brain injuries (TBI), including DoD and VA efforts to identify servicemembers and veterans who were diagnosed with TBI, to establish a joint database on this cohort, and to jointly track the health of the cohort over time.

(4) Annually review the deployment health-related data from the Millennium Cohort Study.

PM 2.3 (a) (1)
Provide an assessment to the HEC on the adequacy of the DoD and VA sharing efforts on identification and outreach to cohorts exposed to chemical and biological warfare agents from 1942 to 1975 by September 30, 2008.

PM 2.3 (a) (2)
Provide an assessment to the HEC on the adequacy of the DoD and VA sharing efforts on the identification and surveillance of the embedded fragment cohort by September 30, 2008.

PM 2.3 (a) (3)
Provide an assessment to the HEC on the adequacy of the DoD and VA sharing efforts on the identification and surveillance of the TBI cohort by September 30, 2008.

PM 2.3 (a) (4)
Provide an assessment to the HEC on the adequacy of the DoD and VA sharing efforts on the deployment health-related data from the Millennium Cohort Study by September 30, 2008.

STRATEGY 2.3 (b)
The HEC Deployment Health Working Group will identify opportunities to share information between DoD and VA on the assessment and screening of deployed populations.

(1) Review DoD and VA reporting mechanisms from screening of servicemembers and veterans for Traumatic Brain Injury.

(2) Review DoD's reporting mechanisms from Pre-Deployment Health Assessments, PDHAs, and PDHRAs.

PM 2.3 (b) (1)
Provide an assessment to the HEC on the adequacy of DoD and VA sharing of TBI screening data by September 30, 2008.

PM 2.3 (b) (2)
Provide recommendation to the HEC on the optimal ways that data from DoD's deployment related health assessments can be shared with VA by September 30, 2008.

STRATEGY 2.3 (c)
The HEC Deployment Health Working Group will identify opportunities to share information between DoD and VA on follow-up medical care of deployed populations.

(1) Annually review the medical follow-up of individuals in the embedded fragment cohort.

(2) Annually review the medical follow-up of individuals in the TBI cohort.

(3) Facilitate the development of the identification of servicemembers (active-duty and retirees) diagnosed with amyotrophic lateral sclerosis (ALS) in the DoD medical system and the transfer of that information to VA for inclusion in the VA National ALS Registry.

PM 2.3 (c) (1)
Develop recommendation for the HEC on the adequacy of the medical follow-up of individuals with embedded fragments by September 30, 2008.

PM 2.3 (c) (2)
Develop recommendation for the HEC on the adequacy of the medical follow-up of individuals with TBI by September 30, 2008.

PM 2.3 (c) (3)
Report to the HEC on the adequacy of a DoD system to include all current and past servicemembers diagnosed with ALS in DoD in the VA National ALS Registry by September 30, 2008.

STRATEGY 2.3 (d)
The HEC Deployment Health Working Group will compare and foster research initiatives on military and veteran-related health research to include deployment health issues.

(1) Conduct an annual inventory and catalog current research on deployment health issues in each Department by September 30th of each year.

(2) Maintain a continuing VA/DoD forum to share findings of deployment health-related research.

(3) Develop an analysis of the ongoing deployment health-related research on an annual basis.

PM 2.3 (d) (1)
Report to the HEC on all DoD and VA deployment health-related research by September 30, 2008.

PM 2.3 (d) (2)
DoD and VA will provide an ongoing forum on a routine basis at Deployment Health Working Group meetings for subject matter experts to share deployment health-related information, including research outcomes and progress.

PM 2.3 (d) (3)
Report to the HEC on all DoD and VA deployment health-related research by September 30, 2008.

STRATEGY 2.3 (e)
The HEC Deployment Health Working Group, through its Health Risk Subcommittee, will develop joint health risk communication products related to deployment health (fact sheets, information papers, pocket cards, and web site documents).

(1) On a quarterly basis, identify emerging health-related concerns, and develop joint health risk communication strategies, messages, processes, and products related to deployment and other aspects of military service.

(2) On a quarterly basis, coordinate health-related risk communication products to ensure consistency among DoD, VA, the Department of Health and Human Services, and other agencies, as appropriate.

PM 2.3 (e) (1)
Report to the HEC that documents emerging health-related concerns and summarizes joint risk communication products that were developed by September 30, 2008.

PM 2.3 (e) (2)
Report to the HEC that documents the deployment related health risk communication products that have been coordinated among federal agencies by September 30, 2008.

GOAL 3 - Seamless Coordination of Benefits

Improve the understanding of, and access to, services and benefits that uniformed servicemembers and veterans are eligible for through each stage of their life, with a special focus on ensuring a smooth transition from active duty to veteran status."

VA and DoD will enhance collaborative efforts to streamline benefits application processes, eliminate duplicative requirements, and correct other business practices that complicate the transition from active duty to veteran status. This will be accomplished through joint initiatives that ensure the wide dissemination of information on the array of benefits and services available to both VA and DoD beneficiaries, enhance educational programming on eligibility criteria and application requirements, and increase the participation in cooperative separation process/examination at Benefits Delivery at Discharge (BDD) sites. This goal encompasses benefits available to VA and DoD beneficiaries, to include health care, educational assistance, home loans, vocational rehabilitation and employment, disability compensation, pension, insurance, burial, and memorial services.

OBJECTIVE 3.1

Enhance collaborative efforts to educate active duty component, Reserve, and National Guard personnel on VA and DoD benefits programs, eligibility criteria, and application processes.

STRATEGIES AND PERFORMANCE MEASURES (PM)

STRATEGY 3.1

The BEC will further expand on efforts to disseminate information on benefits and services available to uniformed servicemembers and VA and DoD beneficiaries throughout the military personnel lifecycle.

(1) Continue to perform established outreach such as letters to Physical Exam Board participants, distribution of A Summary of VA Benefits pamphlets to new recruits at Military Entrance Processing Stations (MEPS) and to graduating cadets and midshipmen at military academies (including Coast Guard).

(2) By December 31, 2007, engage each service branch to identify key accession and service transition points for distribution of A Summary of VA Benefits pamphlets.

(3) By October 31, 2007, coordinate with VA Office of Policy and Planning to align with the required VA national survey to measure awareness of VA's benefits among servicemembers and veterans.

(4) Explore additional opportunities to support Senior Oversight Committee (SOC) initiatives relating to communication of benefits to servicemembers and veterans.

PM 3.1
Expand the distribution of the information about VA benefits through the addition of key accession and training service points by at least 10% each year through September 30, 2010.

OBJECTIVE 3.2

Reach disabled servicemembers eligible to file a claim for VA disability compensation at any of the 130 BDD intake sites with a Memorandum of Understanding (MOU). DoD and VA will increase their efforts to get those service members to file their claim through the BDD Program 180-60 days before separation, retirement, or release from active duty.

STRATEGIES AND PERFORMANCE MEASURES (PM)

STRATEGY 3.2 (a)
The BEC will redefine how to determine annual participation rate metric for usage at 130 BDD sites with MOUs by December 16, 2007.

STRATEGY 3.2 (b)
The BEC will develop a plan to increase servicemember knowledge and awareness of the BDD program at the 130 BDD intake sites with MOUs by March 28, 2008.

STRATEGY 3.2 (c)
The BEC recommends the JEC amend the National MOU between VA and DoD, to allow servicemembers going through the Medical Evaluation Board (MEB)/Physical Evaluation Board (PEB) process to file a disability compensation claim at any of the 130 BDD sites as long as they meet all requirements for filing a claim under the BDD program.

PM 3.2
Once the BDD Working Group redefines the annual participation rate for usage at the 130 BDD sites with MOUs, they will submit the "new" definition to the BEC for approval. Once approved, the BDD Working Group will develop appropriate performance measures by March 28, 2008.

Target
The BDD Working Group will develop and submit new targets to the BEC for approval by March 28, 2008. Once approved, the BDD Working Group will establish performance measures for fiscal year 2009 and 2010.

OBJECTIVE 3.3

Enhance collaborative efforts to resolve issues and improve military paper Health Treatment Record (HTR) processes and facilitate their seamless transfer from DoD to VA for benefits processing in support of servicemembers, veterans, and deployed National Guard and Reserve personnel.

STRATEGIES AND PERFORMANCE MEASURES (PM)

STRATEGY 3.3 (a)

The Medical Records Working Group will operate under the authority of the BEC. The Medical Records Working Group will review paper HTR business processes within DoD and VA to foster improvement in the processes until the paper HTR is decommissioned. The Medical Records Working Group will also ensure coordination between the DoD, VA, and National Archives and Records Administration (NARA) to address paper HTR issues and facilitate recommended solutions.

(1) Review and discuss changes necessary for improvement and propose potential recommendations to resolve HTR issues in a timely manner. Key aspects include:

- Military HTR disposition; and
- Implementation of improved paper military HTR business processes.

(2) Propose milestones and obtain BEC approval for implementation of applicable business process changes.

(3) Review updated regulatory guidance and businesses processes and recommend changes as needed.

(4) Develop Department specific and individual component/organization (e.g., Department of the Army and VA Records Management Center [VA RMC]) specific guidance and procedures with internal controls and accountability.

(5) Monitor execution of the implemented processes to ensure effective resolution of the identified issues.

PM 3.3 (a)

Obtain consensus for a common terminology and definition for paper based health treatment and associated medical and dental record terminologies by December 31, 2007.

PM 3.3 (a)
Finalize update of the Memorandum of Agreement (MOA) between DoD and VA relating to transfer and maintenance of military HTRs for benefits processing and obtain approval and signatures by February 29, 2008.

PM 3.3 (a)
Draft, update and finalize DoD and VA policies to include HTR forms and document contents, management, and transfer by June 30, 2008.

PM 3.3 (a)
Draft and finalize the records disposition schedule for the military HTR and obtain NARA approval and signatures by August 31, 2008.

PM 3.3 (a)
Implement internal control and accountability mechanisms within both Departments by December 31, 2008.

PM 3.3 (a)
Track metrics long term with respect to completeness of the HTRs transferred from DoD to VA by December 31, 2008.

OBJECTIVE 3.4
Improve the delivery of proactive, high-quality, and timely care to servicemembers, veterans and their families through the continuous and integrated provision of clinical and non-clinical case management services in both the DoD and VA systems.

STRATEGIES AND PERFORMANCE MEASURES (PM)

STRATEGY 3.4 (a)
The Federal Recovery Coordination Program (FRCP) will promote optimal health outcomes and quality of life for servicemembers, veterans and their families from recovery, through rehabilitation and ultimately reintegration to the community.

(1) DoD and VA, in collaboration with Public Health Service (PHS) per the MOU with the Department of Health and Human Services, will create the FRCP to ensure that all wounded, injured, or ill servicemembers and their families receive the clinical and non-clinical case management they need.

(2) The FRCP, with the support of an advisory committee and program development consultation from the PHS officer(s) assigned, will provide general guidance to DoD and VA clinical and non-clinical case management programs with regard to: definitions and nomenclature, standards of practice; joint data sharing, joint training standards; roles and responsibilities and competencies; and program evaluation strategies.

(3) The FRCP will produce a comprehensive electronic Resource Directory of national clinical and non-clinical case management resources to equip case managers with easy access to the widest range of services available to serve the wounded, injured, or ill servicemember, veteran and family, by April 30, 2008.

(4) The Federal Recovery Coordinator (FRC) will be assigned to the wounded, injured, or ill servicemembers and families, based on the following criteria: in acute care at an MTF, and a diagnosis of spinal cord injury, burn, amputation, visual impairment, TBI/PTSD, and high severity/acuity level, and at risk (psychosocial and family assessment), and high potential for life long care needs, and willingness to participate (self or family), and/or patient self referral or command referral based on ability to benefit from the services provided. FRCs will initially be stationed at MTFs currently receiving a high number of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) severely wounded, injured, or ill servicemembers.

(5) The FRC will oversee the creation of the patient-focused Federal Individual Recovery Plan (FIRP) to ensure the servicemember, veteran and family receives the needed and designated care through clinical and non-clinical case management at the right time and place by the right provider. The FRC will continue oversight of the FIRP as the servicemember transitions across inpatient/outpatient, treatment/rehabilitation facilities or any site for care, and ultimately to community reintegration. The FRC will be responsible for ensuring that the FIRP is updated regularly in response to the changing needs and goals of the servicemember, veteran and their family.

PM 3.4 (a)
Provide DoD/VA FRCP annual report by September 30, 2008, 2009, and 2010, to include, among other subjects:

- Evaluation of the operation of the FRCP including process and outcome measures associated with quality care and recovery for the servicemember, veteran and family.
- Hiring, training and functional assessment of FRCs.
- Development and use of the FIRP.
- Use of an electronic Resource Directory of national clinical and non-clinical case management resources.
- Survey of the experiences and satisfaction of participating servicemembers, veterans and families.
- Dissemination of lessons learned and recommendations for changes to policy, regulations legislation and practices.

PM 3.4 (a) (4)
Minimum of 10 FRCs will be hired, trained, and fully functioning by June 30, 2008.

PM 3.4 (a) (4)
Eighty percent of veterans (and their respective families) will indicate they are “very satisfied” or “highly satisfied” with the support of their FRC by September 30, 2008, 2009, and 2010.

PM 3.4 (a) (5)
Eighty percent of veterans (and their respective families) will indicate they are “very satisfied” or “highly satisfied” with their FIRP by September 30, 2008, 2009, and 2010.

GOAL 4 – Integrated Information Sharing

Ensure that appropriate beneficiary and medical information is visible, accessible, and understandable through secure and interoperable information management systems.

VA and DoD will utilize interoperable enterprise architectures and data management strategies to support timely and accurate delivery of benefits and services. The emphasis will be on working together to store, manage and share data, and streamline applications and procedures to make access to services and benefits easier, faster, and more secure.

OBJECTIVE 4.1

VA and DoD will utilize their enterprise architectures to foster an environment to support secure sharing of timely, consistent, personnel-related data to enhance service delivery in both Departments.

STRATEGIES AND PERFORMANCE MEASURES (PM)

STRATEGY 4.1

The BEC Information Sharing/Information Technology Working Group will collaborate in developing net-centric solutions for the enhancement of services and benefits delivery to servicemembers and veterans, and reduce legacy data feeds between the two Departments.

(1) Support current and future task force recommendations, while further aligning the HEC and BEC data sharing efforts, to streamline information sharing across the DoD and VA for the delivery of benefits and health care.

(2) Explore other opportunities in support of SOC decisions to leverage data and information in developing a tracking application to support an end-to-end process management for seriously injured servicemembers and servicemembers going through the disability evaluation process while transitioning from active duty status to veteran status.

(3) Complete the implementation of the Identity Management Common Military Population Strategy and Work Plan in order to begin facilitating unique identification, access management, and on-line self service which will assist the delivery of benefits to servicemembers and veterans as well as the management of patients in DoD/VA shared medical facilities by September 30, 2008.

(4) Continue expanding and developing shared servicemember/veteran-centric strategies for DoD and VA web portals leveraging Defense Knowledge Online

(DKO) and Army Knowledge Online (AKO) solutions, and develop service-oriented architectures for enhancing services and benefits in both Departments.

PM 4.1
Reduction in the number of distinct personnel data exchanges between VA and DoD to one from DoD and one from VA by September 30, 2008.

OBJECTIVE 4.2

VA and DoD will structure their health enterprise architectures to support sharing of timely, consistent health data.

STRATEGIES AND PERFORMANCE MEASURES (PM)

STRATEGY 4.2 (a)
The DoD/VA Health Architecture Interagency Group (HAIG) will continue participating in and contributing to standards related organizations such as Healthcare Information Technology Standards Panel (HITSP) and Health Level 7(HL7) in order to improve the availability of shared health information in support of consumer-driven health care and interoperable health information for DoD/VA beneficiaries.

(1) The HAIG will analyze and report to the HEC Information Management/ Information Technology (IM/IT) Working Group on current processes and opportunities to promote health care quality and efficiency through information sharing to empower our beneficiaries by June 30, 2008.

STRATEGY 4.2 (b)
The DoD/VA HAIG will examine the activities in the VA and DoD health architectures that further evolve the areas of provision of health care delivery.

(1) Define, analyze and report to the HEC IM/IT Working Group on VA and DoD health architectural models and specific components that support the shared health architecture in such areas as:

- Case Management by June 30, 2008;
- Disability Determination by June 30, 2008; and
- Health Continuity of Care for our wounded warriors by June 30, 2008.

(2) Identify, analyze and report to the HEC IM/IT Working Group on DoD and VA common services framework to facilitate the secure use of shared architectures by June 30, 2008.

(3) Define version 1 of a Joint Common Services Framework by September 30, 2008.

OBJECTIVE 4.3
Facilitate the adoption of Health Information Technology (HIT) standards for greater interoperability between health systems.

STRATEGIES AND PERFORMANCE MEASURES (PM)

STRATEGY 4.3
VA and DoD will exhibit leadership in the national and Government-wide HIT standards harmonization and implementation arena by participating in the development of health standards, and when mature and available, jointly utilizing health information technology systems and products that meet recognized interoperability standards.

(1) Review national HIT standards recommended for implementation by September 30, 2008 and as health information technology is implemented, acquired, or upgraded, jointly utilize, when available, health information technology systems and products that meet recognized interoperability standards.

(2) Report to the HEC IM/IT Working Group on incorporating recognized interoperability standards into targeted DoD and VA shared technology profile(s), by September 30, 2008.

OBJECTIVE 4.4
Enhance the effectiveness and efficiency of VA access to the electronic health data on separating and separated Military members, and VA and DoD access to electronic health information on shared patients, and support the health IT requirements in the President's Commission on Care for America's Returning Wounded Warriors report.

STRATEGIES AND PERFORMANCE MEASURES (PM)

STRATEGY 4.4 (a)
The HEC IM/IT Working Group will continue sharing electronic health information at the time of a servicemember's separation, while maintaining appropriate security, and support the electronic bidirectional sharing of health information in real-time for shared patients between VA and DoD which will meet the President's Commission requirements for making all essential health data viewable within 12 months.

(1) In coordination with JSP Strategy 4.1(3)VA and DoD will continue to work with the Defense Manpower Data Center (DMDC), Defense Enrollment Eligibility Reporting System (DEERS) to ensure VA patients treated in DoD facilities have DoD Electronic Data Interchange Person Numbers (EDI_PN_IDs) to facilitate

matching patients and sharing electronic health information on shared patients by September 30, 2008.

(2) Begin providing viewable patient health data from theaters of operation to DoD and VA providers on shared patients at fixed facilities to include theater inpatient notes, outpatient encounters, and ancillary clinical data, such as pharmacy data, allergies, laboratory results, and radiology reports by October 31, 2007.

(3) VA and DoD will be able to share viewable ambulatory encounters/clinical notes, procedures, and problem lists in real-time and bidirectional for shared patients among all sites by December 31, 2007.

(4) Begin development of business processes, business rules and requirements validation to automate activation of active dual consumer patients by February 29, 2008.

(5) VA and DoD will be able to share viewable vital signs data in real-time and bidirectional for shared patients among all sites by June 30, 2008.

(6) Implement the automated activation of active dual consumer patient capability by September 30, 2008.

(7) VA and DoD will be able to share viewable family history/social history/other history, questionnaires and forms in real-time and bidirectional for shared patients between all sites by September 30, 2008 – pending funding for both VA and DoD to begin work.

STRATEGY 4.4 (b)
The HEC IM/IT Working Group will support joint efforts to identify areas of convergence regarding personal health records (PHRs).

(1) Complete implementation of education objects for MyHealtheVet (MHV) and TRICARE Online (TOL) by December 31, 2007.

(2) Complete business and technical requirements for authentication and registration portability for MHV and TOL by December 31, 2007.

(3) Complete a white paper on health information portability between TOL and MHV by December 31, 2007.

(4) Document a joint VA/DoD alignment strategy for the delivery of MHV and TOL PHRs by December 31, 2007.

(5) Begin collaboration on a joint performance measurement framework for PHRs in concert with the American Health Information Community by December 31, 2007.

(6) Submit a draft PHR white paper to the HEC IM/IT Working Group by March 31, 2008.

STRATEGY 4.4 (c)
The HEC IM/IT Working Group will support the Education and Training Working Group through the use of e-learning capabilities.

(1) Complete business rules for the sharing of e-learning educational objects between VA and DoD by June 30, 2008.

(2) Implement shared e-learning educational objects between VA and DoD by June 30, 2008.

STRATEGY 4.4 (d)
The HEC IM/IT Working Group will support the electronic sharing of images for shared VA/DoD patients.

(1) DoD will report annually to the HEC IM/IT Working Group on plans to leverage the code in the VA's Imaging System Viewer to support digital imaging within the Military Health System (MHS).

(2) VA/DoD will develop a plan to leverage lessons learned and knowledge gained from the National Defense Authorization Act (NDAA) demonstration projects in El Paso, Texas in conducting a bidirectional pilot test of digital image sharing between six DoD and five VA sites, pending the availability of funds, by June 30, 2008.

(3) VA and DoD will develop a plan for interagency sharing of essential health images (e.g., radiology studies) between VA and DoD by October 31, 2008.

STRATEGY 4.4 (e)
The HEC IM/IT Working Group will support an approach for developing a common DoD and VA inpatient information technology capability.

(1) DoD will begin sharing viewable discharge summaries from Landstuhl Regional Medical Center with the VA providers on shared patients by June 30, 2008.

(2) VA/DoD will define which inpatient data is required to be shared between DoD and VA on shared patients for clinical use as historical reference of a previous inpatient admission by June 30, 2008.

(3) VA/DoD will define which inpatient data is required to share between DoD and VA for clinical use for an inpatient to inpatient inter-Departmental transfer of a shared patient by June 30, 2008.

(4) VA/DoD will define Department-unique and Joint Inpatient Electronic Health Record functional requirements for potential joint application as identified in an operational model (business architecture) at a level sufficient to support subsequent Analysis of Alternative efforts by June 30, 2008.

(5) VA/DoD will provide a report on the Analysis of Alternatives and recommendations for the development and/or procurement of a Joint VA/DoD Inpatient Electronic Health Record by September 30, 2008.

STRATEGY 4.4 (f)
The HEC IM/IT Working Group will provide additional support for implementation of requirements of the President's Commission on Care for America's Returning Wounded Warriors by:

(1) Establishing an information technology plan that will support the use of a recovery plan by the Recovery Coordinator, and will integrate essential clinical and non-clinical aspects of recovery of seriously ill and injured servicemembers and veterans by November 1, 2007.

(2) Developing a plan to execute a single Web portal to support the needs of the wounded, ill, and injured servicemembers and veterans by December 31, 2007.

PM 4.4
Monitor information sharing metrics and report progress to the HEC IM/IT Working Group and to the HEC and JEC as requested. Metrics will include, but not be limited to:

- The number of DoD servicemembers with historical data transferred to VA;
- The number of patients flagged as "active dual consumers" for VA/DoD electronic health record data exchange purposes;
- The number of Pre-and Post-Deployment Health Assessment (PPDHA) forms and PDHRA forms transferred to VA;
- The number of individuals with PPDHA and PDHRA forms transferred to VA;
- Number of chemistry and anatomic pathology/microbiology laboratory tests processed using the Laboratory Data Sharing initiative;
- The number of patients for which digital images have been transmitted electronically from Walter Reed Army Medical Center, National Naval Medical Center Bethesda and Brooke Army Medical Center to VA Polytrauma Centers at Tampa, Palo Alto, Richmond and Minneapolis; and

- The number of patients for which medical records have been scanned and sent electronically from Walter Reed Army Medical Center, National Naval Medical Center Bethesda and Brooke Army Medical Center to VA Polytrauma Centers at Tampa, Palo Alto, Richmond and Minneapolis.

OBJECTIVE 4.5

VA/DoD will foster secure computing and communications infrastructure for electronic patient data sharing.

STRATEGIES AND PERFORMANCE MEASURES (PM)

STRATEGY 4.5 (a)

The HEC IM/IT Working Group will facilitate the development and implementation of a trusted network security and communications partnership in support of electronic health data sharing.

(1) VA/DoD will conduct a map and gap analysis of network security and communications policies which impact the secure transmission of health data between the Departments by March 31, 2008.

(2) VA/DoD will brief the HEC IM/IT Working Group on draft recommendations to influence or change network security and communications policies by June 30, 2008. Where applicable, recommendations will be made to the Department of Commerce/National Institute of Standards and Technology (NIST), The Office of Management & Budget (OMB), and the Department of Health and Human Services for proposed incorporation of findings into Government-wide policy and implementation of policy.

(3) VA/DoD will draft a trusted network security and communications partnership implementation plan for consideration by Office of the Secretary of Defense (OSD) Networks and Information Integration (NII) and VA Office of Cyber Security by September 30, 2008.

(4) VA/DoD will implement a secure network to support health data exchange and provide redundancy by June 30, 2009.

STRATEGY 4.5 (b)

In alignment with and in support of the Office of the National Coordinator (ONC) Nationwide Health Information Network (NHIN) initiative, VA and DoD will study infrastructure interoperability with commercial health care providers to foster infrastructure interoperability that would be accomplished through participating in NHIN-Connect Federal Consortium. VA and DoD will submit a White Paper to ONC summarizing the results of the study by December 30,2009.

(1) Begin an in-depth analysis to identify communications data sharing requirements among managed care support contractors, the VA and DoD by March 31, 2009.

(2) Monitor the HITSP and HL7 for information on the maturity of electronic health record infrastructure, to include security standards, and report to the HEC IM/IT Working Group by January 31, 2009.

GOAL 5 – Efficiency of Operations

Improve the management of capital assets, procurement, logistics, financial transactions, and human resources.

VA and DoD will enhance the coordination of business processes and practices through improved management of capital assets, leveraging the Departments' purchasing power, maximizing the recovery of funds due for the provision of health care services, developing complementary workforce plans, and designing methods to enhance other key business functions.

OBJECTIVE 5.1

The VA/DoD Construction Planning Committee (CPC) will implement a pilot core group process to develop collaborative capital investment opportunities at three sites based upon capital needs and requirements identified by both Departments.

STRATEGIES AND PERFORMANCE MEASURES (PM)

The previous strategies regarding the CPC [Strategy 5.1(a) and Strategy 5.1(b)] have either been incorporated into Objective 5.1, Strategy 5.4 (e) or will be reevaluated after the SOC LOA #5 Facilities work has been completed. Therefore the CPC initiative to develop a nation-wide survey tool of both past and present VA/DoD capital investment collaboration ventures has been suspended.

OBJECTIVE 5.2

Leverage joint purchasing power in the procurement of pharmaceuticals, prosthetics, medical/surgical supplies, high-tech medical equipment and dental and laboratory supplies.

STRATEGIES AND PERFORMANCE MEASURES (PM)

STRATEGY 5.2 (a)
The HEC Acquisition and Medical Materiel Management (A&MMM) Working Group will assess VA and DoD processes related to the acquisition of goods and services and make recommendations to achieve joint operational and business efficiencies.

(1) Review regulatory and policy impediments that prevent further collaborations and report results to the HEC by December 31, 2007, with requests for regulatory changes as needed.

(2) Pursue additional opportunities for joint purchasing consolidation during each calendar year and report to the HEC by December 31st each year for the previous fiscal year.

(3) Pursue VA/DoD Joint Incentive Funding (JIF) to support contractual services to determine measurement of effectiveness of the joint contracting process.

(4) Increase collaborative logistics and clinical participation in standardization programs across DoD and VA. Share standardization business processes and identify any opportunities for DoD/VA standardization.

(a) Analyze and develop new programs and criteria on a continuing basis.

(b) Share spend analysis in areas with opportunities for VA/DoD standardization.

(c) Involve clinical participation from VA and DoD in regional and national standardization programs, trials, and processes, as appropriate.

STRATEGY 5.2 (b)
The HEC A&MMM Working Group will increase the value of joint contracts, targeting commonly used manufacturers for joint contract initiatives and continuing to seek new opportunities for joint contracts.

(1) The A&MMM Working Group will track the number and dollar value of joint contracts and provide joint contract sales.

PM 5.2 (b) (1)
Increase joint acquisition sales realized from the joint procurement of high cost medical equipment by $20 million annually beyond the 2006 baseline level of $150 million.

- Fiscal Year 2007 – $170 million
- Fiscal Year 2008 – $190 million
- Fiscal Year 2009 - $210 million
- Fiscal Year 2010 - $230 million

PM 5.2 (b) (1)
The VA National Acquisition and Logistics Center and the Defense Logistics Agency will report dollars expended within their programs, showing by percent of total expenditures and by dollars, quarterly expenditures in joint contractual vehicles.

STRATEGY 5.2 (c)
The HEC Pharmacy Working Group will identify pharmaceuticals and commonly used products and manufacturers for potential joint contracting action and continue to seek new joint contracting opportunities.

(1) Evaluate 100% of all brand-to-generic conversions (loss of patent exclusivity) within the top 25 drugs as measured by acquisition dollar volume and report the status of the reviews to the HEC on an annual basis, at the first meeting after the end of the first quarter.

(2) Evaluate 100% new molecular entities used in the ambulatory setting for contracting opportunities and report the status of the reviews to the HEC on an annual basis, at the first meeting after the end of the first quarter.

(3) Evaluate 100% of all expiring joint national contracts and report the total dollar value of the contracts over the life of the contract and the total dollar value for the previous year to the HEC on an annual basis.

(4) The HEC Pharmacy Workgroup will evaluate the number and estimated dollar value of purchases for both existing and newly established joint contracts and report the previous fiscal year's data to the HEC on an annual basis, at the first meeting after the end of the first quarter of the new fiscal year.

PM 5.2 (c)
Award a specified number of joint contracts each year.

Fiscal Year 2008	8
Fiscal Year 2009	8
Fiscal Year 2010	10

PM 5.2 (c) (1)
Maximize Joint National Contract Prime Vendor Purchases as percentage of Total Prime Vendor Purchases.*

	VA	**DoD**
Fiscal Year 2008	5.9%	2.5%
Fiscal Year 2009	6.1%	2.6%
Fiscal Year 2010	6.5%	2.7%

PM 5.2 (c) (4)
Maximize Joint National Contract Prime Vendor Purchases expressed as dollar volume (millions).*

	VA	**DoD**
Fiscal Year 2008	$201M	$48M
Fiscal Year 2009	$211M	$49M
Fiscal Year 2010	$229M	$50M

*Footnote:

- The following factors may **decrease** Pharmaceutical Prime Vendor (PPV) purchases.
  - Between calendar year 2007 and calendar year 2012, drugs with a total commercial value of approximately $99 billion have the potential to become generic.
  - In June 2006, simvastatin (Zocor) became generic, VA's drug with the highest volume and highest total expenditures. In the year prior to becoming generic (fiscal year 2005) simvastatin PPV purchases were approximately $196M. In fiscal year 2006 simvastatin purchases were approximately $173M ($93M PPV purchases and $73M direct purchases). With increasing competition in the simvastatin generic market VA anticipates purchases to drop to approximately $23M annually.
  - Of VA's top 15 drugs based on total PPV purchases, 2 became generic between calendar year 2004 and calendar year 2005, with current PPV purchases totaling approximately $117M per year.
  - Of VA's top 15 drugs based on total PPV purchases, approximately 8 have the potential to become generic between calendar year 2007 and calendar year 2012, with current PPV purchases totaling approximately $596M per year.
  - Molecular entity patent expiration does not necessarily guarantee the drug will be marketed. Other issues such as formulation patents, exclusivity, on going litigation and final FDA approval may delay generic competition. These issues may affect the price and availability of product in sufficient quantity.
  - DoD's prime vendor purchases are decreasing by estimated 2% each year. The decrease is a result of several widely used and expensive products becoming generically available and increase in the number of products moved to 3rd tier which make them unavailable at the MTF.
- The following factors may increase PPV purchases.
  - There were 27 new biological and oncology drugs approved and marketed since 2004.
  - In 2004 these drugs accounted for $1.6M PPV purchases and in 2006 these drugs accounted for $30M annual purchases. Most of the new products are in specialty distribution and are not part of the PPV contract.
  - Cholinesterase Inhibitors: The use of these items has increased over the years. In fiscal year 2004 VA purchased approximately $51M and in fiscal year 2006 VA purchased $89 million.
  - Platelet Aggregation Inhibitors: The use of these items has increased over the years. In fiscal year 2004 VA purchased approximately $148M and in fiscal year 2006 VA purchased $202 million.

OBJECTIVE 5.3

Establish a common electronic catalog for Medical Surgical items under contract by both Departments by October 31, 2008.

STRATEGIES AND PERFORMANCE MEASURES (PM)

STRATEGY 5.3 (a)

The HEC A&MMM Working Group will work with industry on uniform identification codes for medical surgical products and strive for consensus between industry and federal partners on a standard format for naming or labeling through A&MMM Working Group.

STRATEGY 5.3 (b)

The HEC A&MMM Working Group will provide methods at the national and facility level to automatically identify the lowest contracted price on medical surgical items.

OBJECTIVE 5.4

VA and DoD will collaborate to improve business practices related to financial operations.

STRATEGIES AND PERFORMANCE MEASURES (PM)

STRATEGY 5.4 (a)

The VA/DoD Federal Health Care Facility – North Chicago will be integrated to the point of having only one financial management system. Consequently, a reimbursement methodology must be developed which takes into account the unique organizational structure. The HEC Financial Management Working Group will assist in the development of the financial allocation/reconciliation methodology to be implemented at the VA/DoD Federal Health Care Facility – North Chicago, determine a mechanism to transfer funds and any legislation required to support funds transfer.

(1) Identify and coordinate legislative action to support funds transfer, if required, by December 31, 2007.

(2) Analyze data and refine methodology between January 1, 2008 and September 30, 2009.

(3) Test methodology by September 30, 2010.

(4) Fully implement by September 30, 2011.

(5) Document lessons learned as progress continues for future similar organizations between October 1, 2006 and September 30, 2011.

STRATEGY 5.4 (b)

The HEC Financial Management Working Group will continue to solicit and recommend JIF projects to the HEC, and will monitor and report the progress of approved projects quarterly.

Develop criteria and methodology to measure the percent of JIF projects progressing at an acceptable rate by December 31, 2007.

PM 5.4 (b)

Report the percent of JIF projects meeting a minimum 85% acceptance rate to the HEC on a quarterly basis starting March 31, 2008.

PM 5.4 (b)
Report to the HEC by September 30th of each year on percent of completed JIF projects that result in new MOAs for project sustainment.

STRATEGY 5.4 (c)
The HEC Financial Management Working Group will review the MOA and scoring criteria for the JIF to ensure proper emphasis is given to corporate direction, task force/review group recommendations, and new legislation for fiscal year 2008. Initial review was completed in September, 2007. Further review to be completed when authorization and appropriation bills are finalized.

STRATEGY 5.4 (d)
The HEC Joint Facility Utilization and Resource Sharing Working Group will oversee VA and DoD efforts to jointly implement the NDAA Demonstration Projects in budget and financial management, coordinated staffing and assignment, and medical information and information technology management.

(1) Conduct demonstration project site visits and assist with completion of final report, transition plans, and lessons learned.

(2) Disseminate lessons learned to VA and DoD staff. Lessons learned will be presented in a VA/DoD breakout session at the MHS Conference in January 2008.

PM 5.4 (d)
Report to HEC on completed projects by March 31, 2008.

PM 5.4 (d) (1)
HEC Joint Facility Utilization and Resource Sharing Working Group co-chairs will conduct final closeout site visits by December 31, 2007.

PM 5.4 (d) (1)
Provide preliminary integrated Demonstration Projects report by June 30, 2008.

PM 5.4 (d) (1)
Provide final integrated Demonstration Projects final report by July 31, 2008.

PM 5.4 (d) (2)
Post project lessons learned on the DoD/VA Program Coordination Office or other identified DoD/VA websites by June 30, 2008.

STRATEGY 5.4 (e)
The HEC Joint Facility Utilization and Resource Sharing Working Group, through its Ad Hoc Joint Market Opportunities Working Group, will assess additional health care markets serving large, multi-Service, DoD and VA populations.

(1) Review and analyze joint venture models and issues identified in Phase I. Report to JEC by October 31, 2007.

(2) Identify Phase II multi-market areas with potential for sharing and develop site visit schedule by December 31, 2007.

(3) Conduct Phase II site visits January 1, 2008 – April 30, 2008.

(4) Report Phase II findings and recommendations to JEC by June 30, 2008.

PM 5.4 (e)
Analyze data from Phase II multi-market areas and develop sharing strategies between May 1, 2008 and June 30, 2008.

PM 5.4 (e)
Report to JEC by June 30, 2008.

GOAL 6 – Joint Medical Contingency/Readiness Capabilities

Ensure the active participation of both Departments in Federal, State, and local incident and consequence response through joint contingency planning, training, and conduct of related exercises.

VA and DoD will collaborate to ensure that plans and readiness capabilities adequately support DoD combatant command contingency requirements and national emergency situations. This collaboration will include the following planning, training, and exercise activities:

- Joint planning to ensure VA support of DoD contingency requirements;
- Collaborative training and exercise activities to enhance joint contingency plans; and
- Improvement of joint readiness capabilities.

OBJECTIVE 6.1

Ensure that joint contingency and scenario-based planning supports VA and DoD requirements.

STRATEGIES AND PERFORMANCE MEASURES (PM)

STRATEGY 6.1 (a)
The HEC Contingency Planning Working Group will develop Departmental plans to support the revised VA/DoD MOA and Contingency Plan and ensure that all VA and DoD Primary Receiving Centers (PRCs) complete local plans to support the VA/DoD MOA and Contingency Plan by March 1, 2009.

(1) Military Departments and VHA provide Service level program implementation guidance to support the VA/DoD Contingency Plan by September 30, 2008.

(2) Report to the HEC the percentage of PRCs that have completed their local plans beginning February 1, 2009.

(3) All PRCs develop local plans by March 1, 2009.

STRATEGY 6.1 (b)
The HEC Contingency Planning Working Group will complete the first annual review of joint contingency readiness capability activities seeking inclusion of VA capabilities and capacities and report findings to the HEC no later than September 30, 2008.

OBJECTIVE 6.2
Collaborate on training and exercise activities that support the VA/DoD Contingency Plan.

STRATEGIES AND PERFORMANCE MEASURES (PM)

STRATEGY 6.2 (a)
In order to establish a unified frame of reference for planning and training, the HEC Contingency Planning Working Group will review common training requirements and joint training opportunities for personnel involved in joint VA/DoD contingency operations. The HEC Contingency Planning Working Group will also facilitate development of a MOA between selected VA and DoD training organizations to ensure funding agreements and space allocation for VA personnel involved in DoD contingency operations.

(1) The HEC Contingency Planning Working Group/Education and Training Sub-group will identify common training requirements for personnel involved in joint VA/DoD contingency operations by October 31, 2007. The identification of such training requirements will include the subjects and topics to be trained, the types and numbers of personnel to be trained, as well as frequency of training.

(2) Validate the catalog of existing joint training opportunities, identify any shortfalls with the Military Departments, OSD, and VA, and provide recommendations for any additional courses by October 31, 2007.

(3) Provide the HEC a report identifying available courses using satellite training resources and a plan to increase awareness of these courses by December 31, 2007.

(4) By July 31, 2008, complete a MOA between DoD and VA permitting individuals from each Department to attend contingency plans and operations training courses without the payment of course fees. Travel and per diem costs will be borne by the parent Department.

(5) Develop a reporting mechanism to track the number of DoD and VA personnel receiving training outside their Department by August 31, 2008.

STRATEGY 6.2 (b)
The HEC Contingency Planning Working Group/Exercise sub-group will review the Chairman of the Joint Chiefs of Staff Exercise Program to ensure that joint tasks (e.g.

patient movement within the continental United States) are included in at least one National Level Exercise annually.

(1) Report to the HEC on outcome of the next review of the Joint Staff Exercise Program by September 30, 2008.

(2) Report to the HEC on joint exercise participation by January 31st of each year.

STRATEGY 6.2 (c)
The HEC Contingency Planning Working Group/PRC Readiness Indicators Sub-group will develop readiness indicators for PRCs by January 31, 2008. Mechanisms to report readiness to VA and DoD will be included.

STRATEGY 6.2 (d)
The HEC Contingency Planning Working Group will facilitate one tactical joint patient movement/reception or disaster response exercise at each VA and DoD PRC every three years beginning in October 2009. Initiate processes within each Department to ensure each PRC is provided $50K at least once every three years.

(1) Submit funding requests by January 31, 2008.

(2) Coordinate exercise schedules by March 31, 2009.